
Michigan's Part B 2009 Statewide Coordinated Statement of Need

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**Michigan Department of Community Health
Division of Health, Wellness and Disease Control
HIV/AIDS Prevention and Intervention Section**

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I. DEVELOPMENT OF THE 2009 SCSN

A. PURPOSE

The *Statewide Coordinated Statement of Need (SCSN)* presents a detailed analysis of the most current knowledge and insight about epidemiological trends and needs of people living with HIV/AIDS (PLWH/A) in Michigan. It is intended to serve as a framework for programmatic action that will strengthen Michigan's collective response to PLWH/A over a three-year planning cycle. Development of the *SCSN* is a requirement of the 2006 Ryan White HIV/AIDS Treatment Modernization Act (RW), which provides federal funding for HIV/AIDS-related care services in Michigan.

B. PROCESS

The 2009 SCSN process, convened by the Michigan Department of Community Health, Division of Health, Wellness and Disease Control, HIV/AIDS Intervention and Prevention Section (MDCH/DHWDC/HAPIS) [i.e., Michigan's RW Part B grantee], was guided by the Michigan HIV/AIDS Council's (MHAC) Needs Assessment Committee. Established in January 2000, MHAC is a joint prevention/care planning body with forty active members and twenty-six expert and at large advisors. The Needs Assessment Committee includes representatives from Michigan's RW-funded organizations and programs. Its structure and composition is intended to facilitate equal representation and responsibility for developing the updated *SCSN* across all RW Parts the MDCH Office of Drug Control Policy, MDCH Bureau of Epidemiology, public health agencies, and various other statewide HIV/AIDS-related organizations.

The primary data source for the current SCSN includes a comprehensive statewide needs assessment process, which took place during 2006. This process was a collaborative effort between MDCH/DHWDC/HAPIS and the MHAC Needs Assessment Committee (NAC).

Two data collection strategies were employed during the needs assessment process. These strategies included distribution of a PLWH/A survey, of which 485 valid surveys were completed and returned, and seven PLWH/A open forums conducted in the outstate areas of Michigan. The outstate is defined as all geographic areas in Michigan *excluding* the Detroit Eligible Metropolitan Area (DEMA). The DEMA, the only designated EMA in the state of Michigan, consists of the City of Detroit and the Counties of Wayne, Oakland, Macomb, Monroe, Lapeer, and St. Clair. The planning body associated with the DEMA, the Southeastern Michigan HIV/AIDS Council (SEMHAC), conducted their own needs assessment and it was agreed by MHAC that any attempt to do a *statewide* needs assessment would be a duplication of effort and costs.

C. VISION

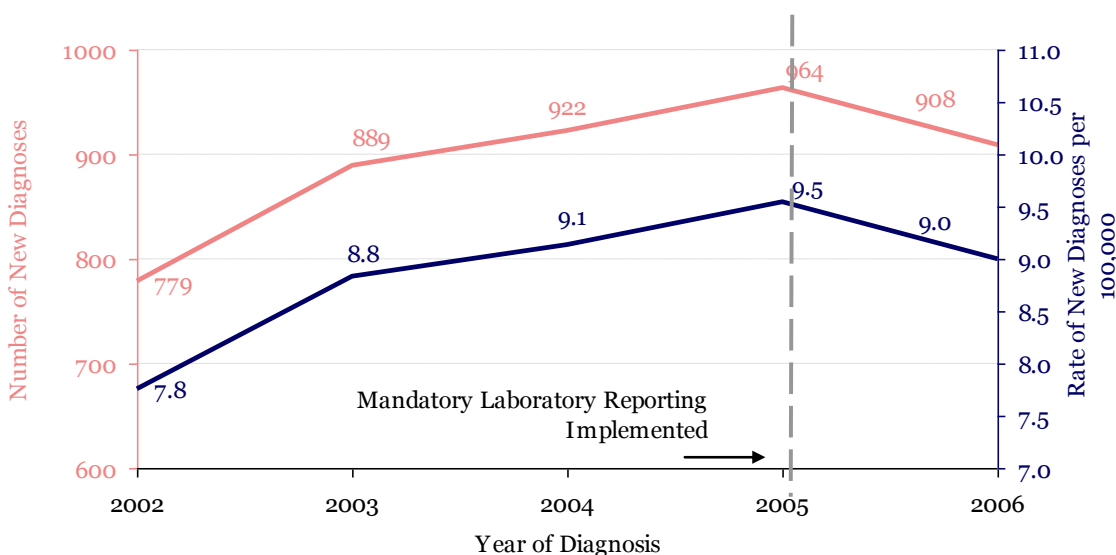
Through compassion, commitment, trust, and self-advocacy, we aspire to develop and maintain a coordinated system of HIV/AIDS services that minimizes the further spread of HIV, provides financial protection from the costs of ill-health, promotes holistic health and well-being, affirms the human right to dignity and respect, generates active membership within our communities, and strengthens cultural awareness and support for diversity.

A report of epidemiologic trends in HIV/AIDS in Michigan, an analysis of the needs of persons affected by HIV/AIDS, an analysis of barriers to accessing HIV-related services, and a declaration of overarching goals for 2009 and beyond are found below.

II. EPIDEMIOLOGIC TRENDS IN HIV/AIDS IN MICHIGAN

The Michigan Department of Community Health estimates that there are 18,000 persons currently living with HIV/AIDS in Michigan, the majority of whom (66%) reside in the DEMA. Most of the remaining 29% live in or around other urban areas of the state (i.e., Lansing, Grand Rapids, Kalamazoo, Flint, Saginaw, Traverse City, and Ann Arbor), although PLWH/A may be found in each of Michigan's 83 counties, as well as 5% in Michigan prisons. As of July 2008, 7,259 persons living with HIV are currently reported to have an AIDS diagnosis.

Overall, per the Annual Review of HIV Trends in Michigan, dated May 2008, the rate of new HIV diagnoses increased by an average of 4% per year, from 7.8 per 100,000 in 2002 to 9.0 per 100,000 in 2006 (779 cases to 908 cases, average 890 cases), after peaking at 9.5 per 100,000 in 2005. The increasing trend and peak in 2005 are most likely due to the implementation of mandatory laboratory reporting in 2005. Prior to this, the HIV Surveillance program in Michigan relied on a few laboratories who voluntarily reported positive HIV-related tests and health care providers, who are required by law to report positive cases. The addition of mandatory laboratory reporting has increased the case reports received, and appear to be driving the upward trend described below.



Between 2002 and 2006, the rate of new diagnoses increased among young adults 13-24 years of age and among persons 40-49 years. Rates in all other age groups were stable. This is the third consecutive year we have seen increases in 13-24 year olds. While the trends we are seeing may partially be attributed to heightened HIV testing efforts aimed at young persons, public testing data suggest that additional testing is not the sole explanation for the increases seen among teens and young adults. In fact, there appears to be a true increase in this group. Alarming, of all

teens and young adults diagnosed in the last five years, 76% are black compared to 59% of persons diagnosed at older ages. Furthermore, young adults are much more likely to be black MSM compared to adults 25 years and older (48% vs. 19%). This continues to underscore a need for prevention campaigns tailored to these groups, as the differences we are now seeing in this young group will likely widen the already large racial gap among persons living with HIV.

The rate of new diagnoses increased among all males (average 4% per year), among all black persons (average 3% per year), and among black males (average 4% per year) between 2002 and 2006. The rates among black males and females are troubling, given that they are several times higher than other race/sex groups.

Between 2002 and 2006, the number of new diagnoses among men who have sex with men (MSM) increased by an average of 4% per year, whereas the number of new diagnoses among injecting drug users (IDU) decreased by an average of 7% per year. Decreases among IDU have been noted for three consecutive years, evidence of the success of programs like needle exchange. The increase among MSM, on the other hand, correspond to other data presented in this report that show increases in new HIV diagnosis rates in black men and young adults.

III. MEETING THE NEEDS OF PERSONS AND COMMUNITIES AFFECTED BY HIV/AIDS IN 2009 AND BEYOND

During 2006, MDCH/DHWDC/HAPIS collaborated with the MHAC Needs Assessment Committee (NAC) to develop and implement a comprehensive needs assessment plan for HIV/AIDS care services in outstate (non-metro Detroit area) Michigan.

The data collection included the distribution of a PLWH/A survey, of which 485 valid surveys were completed and returned, and seven PLWH/A open forums conducted throughout the outstate area.

The results of the needs assessment were used to help develop the 2007 RFP and will continue to be relied upon to help guide future HIV/AIDS care service planning. The next planned assessment of need period will begin in 2009, to drive the next RFP process effective October 1, 2010 to September 30, 2013. This 2009 needs assessment will again be held in conjunction with the MHAC Needs Assessment Committee and Comprehensive Plan Committees. It is fully intended that a PLWH/A survey will be distributed outstate. Due to increasing gas prices and the Michigan economy, open forums may be restructured in order to best accommodate PLWH/A participation.

The following is a brief overview of the findings of the needs assessment process. A full account of the needs assessment results can be reviewed in the document entitled “2006 Part B HIV/AIDS Care Needs Assessment”.

- Across the outstate, the most commonly utilized services were: medical care, case management, and the AIDS Drug Assistance Program (ADAP).

- Across the outstate the services least needed were: harm reduction services, hospice services and child care services.
- Across the outstate service gaps most noted were: oral health and emergency financial assistance.

SERVICE GAPS BY SERVICE AREA:

- For the Mid-South service area the most commonly cited service gap was help paying for rent/mortgage.
- For the Southwest Michigan service area the most commonly cited service gap was oral health.
- For the Central Michigan service area the most commonly cited service gap was oral health.
- For the Western Michigan service area the most commonly cited service gap was oral health.
- For the Mid-Thumb service area the most commonly cited service gap was emergency financial assistance.
- For the Northern Michigan service area the most commonly cited service gap was emergency financial assistance.
- For the Upper Peninsula service area the most commonly cited service gap was support groups.

Addressing these service gaps is a multi-staged process. The needs assessment results will be instrumental in establishing strategies to reduce and eliminate the identified service gaps. For example, oral health is a service provided by the Part B COC program through the Michigan Dental Program (MDP). According to the findings of the needs assessment, three of the seven service areas cited oral health as one of the top three most pervasive service gaps. According to the results, many individuals in need of oral health do not know where to go for assistance and/or have been unable to find a dentist willing to participate in the MDP.

DETROIT EMA

The Southeastern Michigan HIV/AIDS Council (SEMHAC), in collaboration with the Detroit Department of Health and Wellness Promotion (DHWP), administered a needs assessment survey in 2005. There were a total of 554 people who completed the survey; of whom, 438 (or 79%) were HIV positive. The results of this survey showed that 175 (or 40.2%) cited financial help as the top service gap, followed by housing (35.2%), and oral health (34.9%).

Transportation, judgment from others/stigma and lack of information were also cited as barriers to accessing services. Results also showed that of those surveyed, 90.9% were in care. Those not in care (have not received a CD4 count; viral load test; and anti-retroviral therapy/HAART in the past 12 months) stated it was because they could not afford it, had no transportation to obtain the care services or were too depressed to seek care. When these survey participants were asked whether they were not in medical care by personal choice, 23% responded “yes”, while 77% responded “no”.

At the time of the survey, most of the survey participants resided in Wayne County (348 or 81%). The greatest number of HIV positive cases could be found in the zip codes 48213 (29) and 48201 (28). Of those who had housing, a majority (217 or 51%) rent their place of

residence. For those without housing, 93 (22%) of respondents reported that they had been homeless sometime in the past 12 months.

A. ON-GOING AND EMERGING HIV/AIDS SERVICE NEEDS

The data collected during the most recent outstate needs assessment process identified themes related to on-going and emerging HIV/AIDS services needs in Michigan. Their order of presentation does not imply any particular prioritization or weight of importance. The first set of needs includes those revolving around medical care, the second pertains to case management, the third pertains to training issues and the fourth is directed at outreach to those who are not connected to the HIV/AIDS care system.

Service gaps are also presented in part four of this section. The four service gaps discussed are dental care, housing assistance, emergency financial assistance and support groups. For definitions of specific types of health care or support services, see the RW program service definitions included at the end of this document.

1. Issues Surrounding Medical Care Access and Maintenance

Providing quality HIV/AIDS medical care to PLWH/A is a priority at the forefront of current state and federal initiatives. The importance of treatment is not only measured by increased longevity but also by increased quality of life. However, accessing medical care is not always predicated upon a simple formula; individuals might experience barriers both in accessing medical care and maintaining medical care. Issues of access and maintenance barriers as well as medical care patterns and potential solutions will be examined in this section.

a) Coordination of care

The development of new treatment therapies, which has led to longer and healthier living, has also had the consequence of producing a host of additional medical issues (i.e., diabetes, etc.) Coordination of HIV care along with these additional emergent medical issues has become challenging, both for the medical community and for PLWH/As. Increased coordination and communication between primary care physicians, infectious disease physicians and other specialists is crucial toward the holistic treatment of patients.

b) Substance abuse

Substance abuse and/or mental health problems can often cause difficulty with medical adherence and maintaining medical care. The presence of these two problems has been the most commonly cited barrier to accessing and maintaining medical care as reported by case managers in various technical assistance conference calls as well as at the 2008 Case Management Conference.

c) Mental health issues

Mental health problems can also become a barrier for clients who wish to maintain a medical treatment regimen. For some clients who present with moderate to severe mental health problems, it might be difficult to understand the ramifications of treatment and for others treatment of their mental illness might take priority over the treatment of their HIV disease. Previously latent mental health problems might also become active due to the discontinuation of psychotropic drugs and issues of adherence are multiplied when one has to manage the treatment

regimen of two separate illnesses. Finally, the Community Mental Health system was also cited at times as being inadequate to care for many of those who are in desperate need of mental health treatment.

A growing number of newly diagnosed people present with substance abuse and/or mental health problems, which challenges the existing system of HIV/AIDS care services. There is a growing need for trained medical case managers who have strong backgrounds in substance abuse treatment and mental health services. Moreover, the level of need for dually- or triply-diagnosed people often calls for residential treatment programs. However, many programs generally offer only outpatient services. Substance abuse and/or mental illness often generate unstable living conditions and generally poorer health and nutrition.

d) Hepatitis C

Co-morbidity of HCV and HIV is becoming more prevalent. Because this virus is usually transmitted percutaneously and often through sharing equipment between drug users, the Centers for Disease Control (CDC) reports that 50% - 90% of HIV-infected persons who use injection drugs are also infected with the hepatitis C virus. Protection against hepatitis A and B through immunization and ceasing the use of alcohol is recommended for PLWH/A. HIV infection is an important cofactor in HCV disease progression and HCV infection can affect the treatment of HIV. Co-infection with HIV increases HCV viral loads and the rate of progression to cirrhosis. In Michigan, 6,764 cases of chronic hepatitis C were confirmed in 2006.

e) Need for a mechanism to pay for health care

Health care insurance or having access to financial coverage is a necessity for all PLWH/A. Without such coverage, access to even primary care may not be possible. In Michigan, helping clients obtain and maintain coverage is an on-going challenge. According to 2007 calendar year Uniform Reporting System (URS) data that include Parts A - D ADAP, and the University of Detroit, Mercy (dental school), of the HIV+ clients that reported their health insurance status, 35% had no health insurance. Insurance status often depends upon income level. Many PLWH/A have stopped working due to AIDS-related illness or other extenuating circumstances, which often results in a loss of private insurance. If clients have been diagnosed with AIDS and if they meet current low-income guidelines, they are generally eligible for Medicaid insurance.

(i) Medicaid: Approximately one-third of all insured PLWH/A are covered through the Medicaid program. The Supplemental HIV/AIDS Surveillance Project in Detroit found that Medicaid was the most common insurance coverage (51%), with women substantially more likely to use Medicaid (66%) than any other type of coverage. Men were typically using Medicaid (41%) or private-employer insurance (36%). A common frustration for many clients has come from delays in processing Medicaid applications, changes in coverage, or changes in health care location (without being informed). Most PLWH/A with Medicaid coverage must obtain services through a managed care program. At times, Medicaid managed care patients are forced to switch providers because the provider drops its qualified health plan status, thereby no longer accepting Medicaid clients. This has historically been a barrier to important health care services.

(ii) Insurance Assistance Program (IAP) and IAP-Plus: There are two programs that offer assistance with health insurance for PLWH/A. Both programs are administered through the Department of Human Services (DHS). The original IAP program was established in 1989.

Clients must be Michigan residents, have a private health insurance policy with no pre-existing condition exclusion, must be currently too ill to work, or will be too ill to work within 90 days. The monthly income limit is set at 200% of the federal poverty level (FPL) and the cash asset limit is less than \$10,000. The second program is a collaborative project between MDCH and DHS. This program is supported with AIDS Drug Assistance Program (ADAP) earmarked funds and is called the IAP-Plus program. Clients eligible for the IAP-Plus program must be Michigan residents, have a private health insurance policy with no pre-existing condition exclusion, have prescription benefits, and not be eligible for full Medicaid. The monthly income limit is set at 450% of FPL and there is no asset requirement. The IAP-Plus program has the same requirements as ADAP except individuals use their private health insurance instead of ADAP for their medication expenses. Overall, the IAP and the IAP Plus fill important gaps in insurance coverage for PLWH/A.

(iii) AIDS Drug Assistance Program (ADAP): ADAP is a RW Part B-funded program that allows for coverage of HIV/AIDS drug costs for clients when clients are not eligible for Medicaid or other health insurance programs. ADAP reimburses pharmacies for prescription drug costs. ADAP resources support CD4, CD-8, viral load, genotype, and Monogram Biosciences Tropism testing for ADAP clients. ADAP resources are also used to cover the cost of pharmacy co-pays, which could otherwise be prohibitive. As the cost of anti-retroviral drug prescriptions and other pharmaceutical treatments increase, ADAP continues to be a valuable and necessary service.

While most were satisfied with ADAP services, many clients also had suggestions for improvement. The most commonly mentioned barrier to accessing ADAP services, as reported by ADAP survey respondents, was the redetermination process. ADAP clients took the time to comment on the process and offer suggestions about how it might be streamlined.

To expedite the ADAP redetermination process, a new standardized Financial Assessment Tool was developed and implemented by DHWDC/HAPIS in June 2005. This form is used by case managers throughout the state and is a requirement within the Standards of Service for HIV/AIDS Medical and Non-medical Case Management in Michigan.

This financial assessment tool was developed to assure that all case management providers collect similar financial data on all clients who receive case management and other support services, which require that funds are used as "last resort." The form is completed by the case manager, and when necessary and with the consent of the client, is transmitted to the Department of Human Services (DHS) which will query the DHS Client Information Management System and Social Security Administration systems to determine if that client is receiving (or has pending) Medicaid or other entitlements, and/or to determine if they may qualify for such benefits before Part B ADAP resources are used. DHS prepares a brief summary and transmits it back to the case manager. If the client is determined ineligible for DHS services, the client summary form is then used as the Medicaid denial for ADAP purposes. The client is then exempt from applying for Medicaid.

f) Alternative Medical Sites

The distance a client needs to travel to receive treatment can further complicate access to medical care. In addition, those living in rural areas of the state report a lack in the availability

of infectious disease physicians while those living in urban areas of the state experience large patient loads and at time experience difficulty obtaining a timely appointment.

Traveling long distances to a medical facility is not only cost prohibitive for many, but also becomes increasingly difficult for individuals who are in poor health. In the Detroit Eligible Metropolitan Area (DEMA) mobile services travel throughout the area, providing Early Intervention Services (EIS) such as counseling, testing and outreach. Early Intervention Project (EIP) substance abuse services are funded by the Department of Health and Wellness Promotion, Bureau of Substance Abuse. MDCH, DHWDC/HAPIS provides funding for an additional van for provision of care services. Mobile services are available during non-traditional hours, and are targeted to substance abusers in treatment, commercial sex workers and individuals most disenfranchised, including the homeless.

Establishing tele-medicine sites and satellite sites are being considered as viable ways to increase access to, and maintenance of, medical care for those living in rural communities. Newly funded medical sites in 2007-2008 include two health departments. Ingham County Health Department provides ambulatory outpatient care and Central Michigan District Health Department provides case management and other supportive services. It is anticipated that 500 people will receive primary and specialty care through the Ingham County Health Department with Part B/MHI resources.

2. Need for modified HIV/AIDS case management services

In 2006, a number of people explicitly stated that many AIDS service organizations were operating under an outdated case management system designed for acute comprehensive care, and others reported that many case managers were overwhelmed and were at risk of burnout. At that time, those issues reflected the changing dynamics of the HIV/AIDS epidemic. Since then, the DHWDC/HAPIS has revised the Standards of Service for HIV/AIDS Case Management twice, and in 2007 developed new Standards of Service for HIV/AIDS Medical Case Management and Non-medical Case Management. Additionally, new universal standards and Culturally and Linguistically Appropriate Services (CLAS) Standards were developed

These new standards are innovative in the design and place greater focus on care, treatment, medication adherence, and medical follow-up and monitoring. They more adequately accommodate long-term care for multiple-need clients. These standards (1) facilitate access to and sustain clients in primary care, and (2) facilitate a process of self-determination that helps clients effectively manage their HIV care needs. Over the past several years, a variety of approaches have been implemented, namely: (1) tailoring service delivery for both higher and lower need clients, (2) building community-based, multi-disciplinary care teams, (3) creating multiple points of access to services, and (4) streamlining the client referral process.

a) Tailoring service delivery for higher and lower need clients

Although some clients may need less intensive case management services, a growing number of clients, particularly newly diagnosed clients and multiply-diagnosed clients, present with substantially higher needs. Higher need clients tend to present with a variety of challenges, in addition to HIV, such as housing difficulties or homelessness, poverty, mental illness, and substance abuse. In addition, an increasing number of clients have had very little formal education and many are functionally illiterate.

In contrast to higher need clients, lower need clients are persons who are HIV positive, but relatively healthy and self-directed. They are not in need of comprehensive support services; but seek advocacy assistance and do not want to be in case management. It was therefore suggested that case managers be equipped with the ability to provide brief, one-time or short term referral services to clients without enrolling them into medical or non-medical case management services.

b) Building community-based multi-disciplinary care teams

Regardless of whether a client is a higher need or lower need client, sources suggest that some clients are frustrated by a lack of service coordination. Most PLWH/A are generally in need of long-term, chronic care, and newly diagnosed clients usually present with a variety of needs, such as mental health and substance abuse treatment; legal services; housing; emergency financial assistance; medical care; and/or transportation. Because of the array of needs, there is a need for multi-disciplinary care teams.

c) Creating multiple points of access to services

Another characteristic of some of the organizations providing services is that clients who may enter care through the substance abuse ‘window’ or the mental health ‘window’ are not told about HIV/AIDS services, such as testing, counseling, and case management. An initiative that links substance abuse and HIV services is the Early Intervention Program (EIP). These programs (approximately 16 in Michigan) provide both prevention and care services to persons who are at-risk of, or newly diagnosed with HIV, and who also have a substance abuse treatment need. HIV case management agencies are often subcontractors with one or more substance abuse coordinating agency. Such arrangements have worked relatively well, although a greater allocation of resources for coordination of joint HIV/substance abuse programming is needed.

d) Streamlining the client referral process

Another aspect of the challenges currently faced by case management services involves the need for streamlined service referral. Reports show a growing level of frustration in some locations regarding an HIV/AIDS service system that is fragmented. Providing support services, such as housing and transportation assistance, to PLWH/A throughout the state is complicated mainly because each of these types of support services are provided by separate systems of funding, separate and differing eligibility criteria, and different administrative agencies. The results also reveal the need to develop collaborative networks among clients and service providers. A web-based or telephone-based service that streamlines information about and/or referral to HIV/AIDS services is one way to meet this need. Virtual information systems may address the need for more effective referral systems for clients in rural areas of the state, particularly if they are designed to serve transient migrant workers. Web access, however, may be a challenge for persons who are low-income.

3. Need for provider and case manager education training

The changing epidemic and the rapid changes in treatment options make education of service providers an on-going need. The principal barrier that keeps providers from receiving the education they need about recent advances in new knowledge about HIV care is taking time away from work, insufficient funds, and feeling like additional training is not needed. The education needs of health care providers and case managers are presented below. To address this

need, the document entitled, “Standards of Service for HIV/AIDS Medical and Non-medical Case Management in Michigan,” was revised in 2005 and again in 2007 to include greater emphasis on incorporating prevention/risk reduction education, medication adherence counseling and secondary prevention practices into the case management model and case management certification trainings. This was a significant change to the standards and it is anticipated that the result will be a greater number of providers seeking testing and improved health outcomes.

a) Improve communication

In order to provide the most effective continuum of care possible for PLWH/A, HIV/AIDS service providers must be kept up-to-date about innovative prevention programs, current issues regarding HIV/AIDS testing and diagnosis, the latest treatment guidelines (including co-morbidity care), effective psychosocial support interventions, and changes/enhancements to the HIV/AIDS service delivery system. Coordination and linkages among HIV/AIDS service providers is essential. Counseling, Testing and Referral (CTR) and Partner Counseling & Referral Services (PCRS) are key opportunities for coordination and collaboration among health and human service providers of HIV-related services. According to Michigan Communicable Disease Rules, promulgated under the authority conferred on the Department of Community Health section 51111 of Act No. 368 of the Public Acts of 1978, as amended being 33.5111 of the Michigan Compiled Laws, physicians are required to report AIDS cases to the local health department within 24 hours of discovery or diagnosis and HIV infection as soon as possible, within 7 days of discovery or diagnosis.

The Wayne State University AIDS Research and Education Center and the Midwest AIDS Training and Education Center (MATEC) report the following education needs of health care providers: zero to low-volume providers need instruction on risk assessment, counseling and testing, early diagnosis, current treatment guidelines, drug-drug interactions and the co-morbidities of syphilis, Hepatitis C, substance abuse, and mental illness. They also need assistance in developing linkages with high-volume providers (i.e., HIV-specialists) for clinical consultation in treating PLWH/A, and on linking clients with community resources. Needs of medium-volume providers include current treatment guidelines, drug-drug interactions and the co-morbidities of syphilis, Hepatitis C, substance abuse and mental illness. High-volume providers' education needs include integrating HIV-care into substance abuse treatment and /or mental health care. Overall, health care providers need education on cultural competency and on incorporating HIV-care into general health promotion care. Health care providers who care for women of childbearing age need education on the Michigan law regarding HIV testing and counseling of pregnant women and on current treatment guidelines for HIV-positive pregnant women.

Dental professionals need instruction on oral manifestations of HIV disease, drug-drug interactions, HIV stigma, Hepatitis C, antibiotic pre-treatment and current infection control guidelines. They also need assistance in developing collaborative relationships with physicians and instruction about how to participate in the Michigan Dental Program.

Pharmacists need instruction on current treatment guidelines, drug-drug interactions and drug-lifestyle interactions (e.g., prescribed and alternative therapies, psychosocial issues that affect adherence to treatment), as well as HIV stigma.

b) Increase knowledge among case managers and health care providers

Similar to other health care providers, case managers need knowledge about a variety of HIV topics and issues. These topics include the need for more knowledge regarding the medical aspect of HIV and various co-morbidities. Examples of topic areas include treatment guidelines, side effects, hepatitis C, mental health/substance abuse issues, and identifying and working with multi-diagnosed clients. Case managers and client advocates have also expressed a need for additional training surrounding the following topics: ethics, cultural sensitivity, rural prevention strategies, immigration laws pertaining to undocumented citizens, sexual history assessment and risk factors, back to work issues, and changes/enhancements to the HIV/AIDS service delivery system. Finally, there was also an expressed need for training revolving around agency capacity building topics such as program evaluation, building agency infrastructure, and grant writing.

4. Outreach to the unconnected

As RW programs mature and increase efforts to adapt to the changing nature of the epidemic, focus has expanded to include individuals not receiving medical care or not part of the current HIV/AIDS continuum of care.

With this in mind, DHWDC-HAPIS asked agency staff from local AIDS Service Organizations to share their ideas on how these individuals could be reached and brought into care. The ideas and comments gathered were wide-ranging and plentiful, and could be categorized into one of three themes or categories: (a) agency connectedness and operation, (b) media solutions, and (c) outreach activities.

a) Agency connectedness and operation

Providers spoke of the need for establishing and maintaining existing agency collaboration and connectedness in order to facilitate the process of identifying those who are not in care.

The following suggestions were made to help facilitate interconnectedness between agencies and to support agencies with expanded capacity to serve those who are not connected to the current service delivery system.

- Continue to strengthen the relationship with DHS, which involves the mutual exchange of information about community resources for PLWH/A.
- Linkages between ASOs and other community programs/agencies (i.e., needle exchange programs, local health departments, etc.) should also be strengthened. With the implementation of CAREWare, version 4.1, sharing between agencies and the tracking of clients and referrals should improve this linkage.
- Maintain and/or develop close working relationships with all counseling and testing sites, infectious disease physicians as well as primary care physicians to facilitate referrals.
- Agencies who serve PLWH/A should offer services during non-traditional hours for those who are employed.
- Agencies who serve PLWH/A should offer services via non-traditional methods (i.e., mobile vans for hard to reach populations).
- Employ agency staff that reflects the clientele they serve.

b) Disseminate information

Providers also suggested media solutions to convey information about HIV testing sites (community based and local health departments), services available for PLWH/A, and other

information that might reach those who are at risk and those who are positive but are not connected to the HIV/AIDS continuum of care service delivery system. The following solutions were suggested as viable options for disseminating information:

- Post flyers or posters at bus stops, buses, train stations, and health clinics.
- Advertise in local magazines (i.e. PFLAG, Gay-Lesbian materials).
- Create public service announcements on television.
- All infectious disease doctors should maintain information boards in their offices.
- ASOs and physicians should routinely provide clients with updated medical information.
- Educational forums conducted at schools and health fairs could be a good venue for information dissemination and education about the disease in order to lessen the stigma of HIV/AIDS.
- Place informational brochures in diverse locations (e.g., health fairs, gay bars, pharmacies, physicians' offices, local health departments, substance abuse facilities, etc).
- Maintain a website which displays services available according to county of residence.
- Providers also wanted to see more information disseminated to the public in the form of advertising about available services, media outreach that is both linguistically and culturally appropriate, open education in the schools and the PLWH/A community becoming more active by spreading the word about living with HIV.

c) Conduct outreach

Various types of outreach activities were also thought an important component of any plan to reach those unconnected. Outreach activities that are more interactive than media solutions, where information is only disseminated, are key. The most commonly mentioned method of reaching those who are unconnected was case finding. Outreach work could potentially be expanded at local health departments, substance abuse treatment centers, community mental health agencies, pharmacies, counseling and testing sites, low income housing sites, shelters, churches, health fairs, and emergency rooms. Contacts could also be established with local hospital and infectious disease doctors.

B. Service Gaps

Based on the results of the PLWH/A survey distributed in 2006 as part of the statewide needs assessment, the most frequently cited service gaps were emergency financial assistance, dental care, housing (assistance paying for rent/mortgage) and support groups or buddy/companion services. Providers have been informed that Part B funds should only be used for housing if HOPWA funds are not available.

The following sections will explore the barriers to accessing these needed services.

1) Emergency financial assistance

As the most commonly mentioned service gap, PLWH/A survey respondents report they needed emergency financial assistance (EFA), but could not access it. EFA is available to cover expenses such as transportation, food, essential utilities, or medication assistance to those who are eligible.

Current levels of EFA seem to be inadequate to support the growing need for financial assistance. As the most commonly mentioned outstate service gap, EFA was also ranked in the

top three service gaps for most of the regions. Further analysis also shows that women and individuals not in case management were *more likely* to report EFA as a service gap.

When asked why EFA was considered a service gap, most commented that there was limited funds, stringent income restrictions, red tape involved in acquiring EFA and some reported that they did not know this service was available. For example, one survey respondent wrote that there is “too much red tape to get [EFA] – then they refuse anyway.”

Other respondents and PLWH/A open forum participants noted that because these funds are emergency in nature, they are not designed for someone who needs financial help to stay out of an emergency situation. This was frustrating for clients because they had to be in a state of financial crisis before qualifying for aid.

Case management providers have allocated a total of approximately \$29,242 to this service category for grant year FY2008. This amount is less than prior grant years; however, it is likely that providers have identified trends in use of emergency financial assistance (EFA) dollars, and have allocated those dollars directly to high need service categories where the EFA funds are likely to be expended, i.e., reimbursements for medical visits, food vouchers, utilities and transportation. A decrease in allocations to EFA may also reflect continuing pressure to fund core services in an environment of level or reduced funding.

2) Dental care

Current publicly-funded dental care coverage for PLWH/As includes the Michigan Dental Program (MDP), which pays for prophylactic and restorative dental services for PLWH/A in Michigan who are uninsured. The need for dental insurance is significant for PLWH/A, many of whom do not have insurance policies that cover either regular or special dental needs. Although Michigan Medicaid provides adult dental services, they do not cover periodontal care, which is covered by the MDP for PLWH/A. Enrollment for MDP is currently closed in order that services can be covered for those 1,644 individuals already on the program.

When this project was first initiated in May 2000 as the Michigan Dental Demonstration Project, learning how to access these benefits presented difficulty for some clients, mainly because most dental providers in the program had requested that their contact information not be listed openly.

While previous needs assessment have also identified dental care as a great need, which was a compelling reason to establish a program such as the MDP, current needs assessment results have found similar results. Despite the establishment of the MDP and ongoing efforts of the University of Detroit-Mercy, and perhaps because of the Medicaid coverage restrictions, many PLWH/As in the past have reported not being able to access dental care. PLWH/A survey respondents reported dental care as the second most commonly cited service gap, in which they reported they needed dental care but could *not* access it. Currently, of the 1,644 people on the MDP, approximately 18% are University of Detroit-Mercy clients. The University of Detroit-Mercy serves approximately 400 HIV-infected clients, and had served 161 new HIV-infected clients between January – June 2008. This increase in availability of services is an attempt to decrease dental care need; however, the University of Detroit-Mercy still receives two to five new applications daily requesting care.

Contextual information collected from provider interviews and PLWH/A open forums also support this finding. Some providers have pointed to the fact that it has been very difficult to find dentists willing to participate in the MDP or willing to accept Medicaid.

Some PLWH/A survey respondents reported the same difficulty in finding a dentist willing to participate in the MDP while others cited their lack of dental coverage and inability to afford dental care or co-pays as the primary reasons for not being able to access this service.

It is interesting to note that while dental care does represent a service gap in the HIV/AIDS care system; there are also many who have accessed dental care successfully. The only indication of difference appears based on a client's geographic residence. Clients who resided in the Southwest area of MI, Central MI area, Western MI, and Flint-Saginaw-Bay City area ranked dental care as the top two most commonly cited service gaps. Differences in gender, race/ethnicity, AIDS status, case management status were also considered but revealed no significant findings.

3) Housing: Assistance paying for rent/mortgage

Survey and open forum data affirmed a growing need for housing-related supportive services for PLWH/As throughout the state. Survey respondents were asked not only about their need for direct housing services (i.e., financial assistance for rent/mortgage) but also about the potential need for supportive services, such as assistance with locating housing. Most cited a profound need for housing financial assistance and a much lesser need for indirect assistance.

Direct housing assistance tied as the third most commonly mentioned service gap, in which survey respondents citing housing/and paying for their mortgage as a need they could not access. After closer examination of those who could not access housing, it was found that men, individuals who reported being white and those not in case management were *more likely* to report housing as a service gap.

When open forum participants and survey respondents were asked why they could not access direct housing many reported that they did not qualify because of stringent income requirements. For example one respondent wrote, “[my] financial situation [is] just enough to keep me poor”. As stated previously, providers have been informed that Part B funds should only be used for housing if HOPWA funds are not available.

4) Support groups/buddy or companion services

A commonly mentioned service gap amongst both open forum participants and survey respondents was the need for services that provide the space for PLWH/As as well as other affected partners, friends, and family members to develop the skills needed to cope with the challenge of living with HIV. As PLWH/A are living longer, the fatigue (mental and physical) and the sense of vulnerability that accompany an HIV diagnosis are more palpable today than ever before. There is a need to create many different types of supportive settings for the different types of situations and personalities that are the face of HIV/AIDS.

During several open forums the issue of support or connectedness to other PLWH/As was discussed in terms of needing to be able to foster a shared learning about treatment, medical care, resources, etc. Some participants felt this connectedness did not exist in their community partially because of confidentiality concerns revolving around fear of disclosure and breach of

confidentiality by other support group participants. This was of particular concern in areas which are considered rural.

This final service gap tied as the third most commonly mentioned service gap. Of these respondents, those who identified themselves as white were more likely to report support groups as a service gap.

Although the survey and open forum data state the lack of support groups is a gap, it is not a core service and has not been identified as a high priority need. MDCH-DHWDC continues to emphasize core services to the greatest extent possible. However, Part B funding is provided to one contractor in Flint (Wellness AIDS Services, Inc.) for a pilot program entitled “Treatment Education Adherence Program,” which is designed to promote treatment education counseling and adherence for PLWH/A. It serves as a venue to improve the level of adherence and as an adherence support group.

Even though not funded via MDCH-DHWDC, all Michigan providers offer some type of support group to address PLWH/A need. A complete resource directory for PLWH/A can be found at Michigan Go Local (MGL) which lists current health services in Michigan:

www.medlineplus.gov/mi. Information on DEMA area resources can be found at:
www.lib.wayne.edu/dcal.

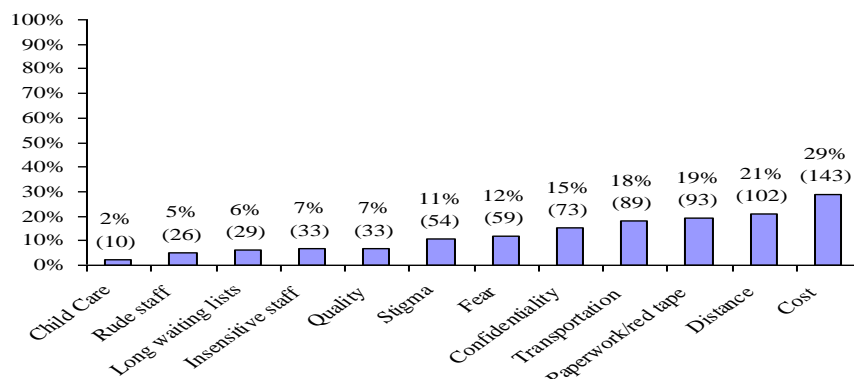
The following table lists 2006 service gaps in rank order:

Service Categories	Outstate
Emergency financial assistance	1
Dental Care	2
Housing: Help pay for rent/mortgage	3 (tie)
Buddy/Companion services	3 (tie)
Professional Mental Health Counseling or Therapy	5
Psychosocial support: Support groups	6
Legal assistance	7 (tie)
Food bank/pantry	7 (tie)
Housing: Help finding housing	9 (tie)
Client advocacy	9 (tie)
*Employment services (not funded by Ryan White)	11
Help disclosing status to others	12 (tie)
Transportation	12 (tie)
Nutritional counseling	14
Emergency financial assistance: Non-Rx Drugs	15 (tie)
Health Education/Risk Reduction: HIV info for friends/family	15 (tie)
Health Education/Risk Reduction: Medical info about HIV/AIDS	17 (tie)
Substance abuse services: Help quitting drug/alcohol use	17 (tie)
Child care services	17 (tie)
HIV Drugs	24
Treatment adherence services	20 (tie)
Substance abuse services: Help managing drug/alcohol use	20 (tie)
Health Education/Risk Reduction: Harm reduction services	20 (tie)
Hospice services	20 (tie)
Medical Care	--
Case Management	--

C. BARRIERS TO ACCESSING HIV/AIDS SERVICES

A barrier is defined as any personal or system-related circumstance that inhibits or restricts access to one or more needed services. Twelve barriers were identified: cost, distance, paperwork (red tape), transportation, confidentiality, fear, stigma, quality, insensitive staff, long-waiting lists, rude staff and childcare.

Figure 124: Barriers to HIV-related Medical Care



While all of the respondents were receiving medical care for their HIV at the time of the PLWH/A survey, they also had a lot to say about what has made access to medical care in the outstate a challenge. Figure 124 shows the most commonly cited barrier (29%) to medical care was the cost involved in accessing care. Less than one-fourth (21%) also reported distance was a barrier to care.

The third most commonly cited barrier to medical care was the paperwork and red tape involved in accessing care. Several reported fear and stigma as barriers to care. Forum participants also identified stigma as a significant barrier. Many mentioned finding a doctor was not a problem, but for some forum participants having some sort of network of PWAs would be helpful to reduce the barriers they experienced. This network could serve as an information exchange conduit where inside information could be exchanged about what has worked and not worked and how to deal best with the system.

Even though forum participants traveled to the open forums, they mentioned the difficulty associated with going to and from medical appointments. This was voiced as well by survey participants.

Funding alternative medical sites is one way MDCH-DHWDC is trying to improve the distance between PLWH/A and their medical care. Keeping as many PLWH/A on ADAP as possible, without creating a waiting list, is another way in which MDCH-DHWDC helps PLWH/A deal with the cost of medications. It was a priority of MDCH-DHWDC to address the barriers that deal with agency quality and insensitive/rude staff. This was addressed by revising the Standards of Service for HIV/AIDS Case Management, and in 2007 developing the new Standards of Service for HIV/AID Medical Case Management and Non-Medical Case Management. The implementation of universal standards and Culturally and Linguistically

Appropriate Services (CLAS) Standards were also implemented to better serve Michigan PLWH/A and decrease barriers to care services.

IV. OVERARCHING GOALS

In addition to supporting the thirteen core services defined by HRSA (outpatient/ambulatory health services; ADAP treatments; AIDS pharmaceutical assistance; oral health care; early intervention services; health insurance premiums and cost sharing assistance; home health care; home and community-based health services; hospice services; mental health services; medical nutrition therapy; medical case management (including treatment adherence); and substance abuse services – outpatient), the following three goals have been developed to reflect the comprehensive set of needs of people and communities affected by HIV/AIDS: (1) decreasing unmet need (2) building system capacity and effectiveness through collaboration and coordination, and (3) developing and evaluating a clinical quality management program.

A. DECREASING UNMET NEED

UNMET NEED ESTIMATE

Population Estimates

The Unmet Need Framework shows that for the time period (October 1, 2005 – September 30, 2006) there are an estimated 5,741 persons living with HIV and 6,883 persons living with AIDS for a total of 12,624. This is lower than the data shown in Section II: Epidemiologic Trends in HIV/AIDS in Michigan, due to different HIV diagnosis dates as described below. Although the Framework requests the number of persons who are aware of their status, HIV surveillance is not able to capture HIV status awareness. Thus, the estimates in the Framework include all persons reported to surveillance, whether aware of their status or not.

Estimates of People with Met Need

The Unmet Need Framework shows 7,351 people estimated have met need.

Estimates of Unmet Need

The Unmet Need Framework shows 5,273 people estimated to have unmet need. (Note: May be in care, and not seen frequently, i.e., at least every 12 months.)

Data Sources and Estimation Methods Used

The following methodology was used in order to estimate unmet need for HIV-related primary care in Michigan.

First, two existing databases were selected:

- *The e-HIV/AIDS Reporting System (eHARS)*. eHARS is the surveillance database that contains information on all reported cases of HIV/AIDS in Michigan, and is the database that replaced HARS. eHARS contains the population-based data needed to determine the population size of HIV-infected persons. Both HIV and AIDS are notifiable conditions in Michigan, so both are included in eHARS.

Laboratory Database. Mandatory laboratory reporting in Michigan was implemented on April 1, 2005 for positive diagnostic HIV tests and July 1, 2005 for all HIV viral load and CD4 tests. These laboratory results are contained in an ACCESS database maintained by the HIV Surveillance program.

Second, “care” was defined as having a laboratory result for a CD4 count and/or percent or a viral load measure during a 12 month time period (October 1, 2005 through September 30, 2006) among patients in eHARS. Use of anti-retroviral therapy was not included in the definition of care because HIV Surveillance does not collect this information. However, it is believed that the vast majority of patients on medication regularly have CD4 and viral load tests run, and that there are few, if any, patients in care who are missed using laboratory data only.

Third, laboratory data were used to determine each patient’s most recent CD4 count, CD4 percent, and/or viral load test date. These laboratory results were then joined to surveillance data in eHARS. Persons diagnosed after September 30, 2005 were excluded from analysis to eliminate the possibility of including those who were very recently diagnosed and had not yet obtained care. Unmet need was then calculated by determining the number of persons in eHARS who were diagnosed prior to October 1, 2005 and had not received a viral load or CD4 test between October 1, 2005 and September 30, 2006.

While the combination of laboratory and surveillance data offers an ideal way to measure unmet need, there are some limitations to the data that should be noted. As mentioned above, mandatory laboratory reporting is new in Michigan. Thus, some laboratory results may not have been captured by the laboratory database as laboratories were rolled into the new reporting requirements. However, all major labs that were rolled into the new requirements at a date later than anticipated provided historical lab data, so this is not likely to be a major source of discrepancy. In addition, persons who move out of state will automatically be counted as unmet need cases if Michigan’s HIV Surveillance Program is not notified of the changes in residency. Michigan’s HIV Surveillance Program participate in Routine Interstate Duplicate Review (RIDR), in which Michigan collaborates with other states under the guidance of the Centers for Disease Control and Prevention to assess and resolve potential case matches between the states. This effort limits the possibility of residency affecting unmet need, although not all states participate in a timely way. Similarly, if a person died and Surveillance was not notified, that person would be counted as an unmet need case. Michigan’s HIV Surveillance Program also conducts a death match annually to minimize this undercount. Finally, there inevitably is room for error in the laboratory reporting system. For example, cases can potentially be falsely matched or non-matched to the surveillance database. Overall, however, the laboratory reporting system is strong and checks are in place to ensure the quality of those data.

Assessment of Unmet Need: Analysis of Those Not in Care

- Demographic data

Of the 5,273 persons with unmet need, 77% are male and 23% are female. This distribution of sex is the same among persons with met need. Persons with unmet need are more likely than persons with met need to be IDU (16% versus 11%), and less likely to be MSM (43% versus 50%). Persons with unmet need are very similar to persons with met need according to age at HIV diagnosis and current age. The median age at HIV diagnosis is 34 years and the median

current age of all cases is 42 years. The majority of persons with HIV, whether met or unmet need, are black, non-Hispanic (57%) or white, non-Hispanic (37%). Persons with unmet need are more likely to live in out-state Michigan (40%) than those with met need (33%).

The percentage of unmet need is highest among persons with IDU (51%), MSM/IDU (48%), or No Identified Risk (56%) mode of HIV transmission. In addition, persons who are adolescent or young adult at HIV diagnosis have higher proportions of unmet need than other age groups (46% among 13 – 19 year olds and 48% among 20 – 24 year olds). Hispanic persons living with HIV have the highest proportion of unmet need (50%) according to race/ethnicity. Asian/Pacific Islanders also have a high percentage of unmet need (49%), but the number of persons in this group is too small to allow us to draw definitive conclusions about the level of unmet need in Asian/Pacific Islanders in Michigan. In terms of geography, those living in out-state Michigan have a higher percentage of unmet need (47%) compared to those living in Southeast Michigan (39%). In particular, the Lansing—East Lansing (70%) Metropolitan Statistical Area (MSA) and Jackson MSA (58%) have high proportions of unmet need. Based on the analysis of unmet need estimated for various sub-populations in Michigan, the State will place increased emphasis on outreach to people living with HIV not AIDS, IDU or MSM/IDU, adolescents and youth, and people living in the outstate areas, particularly in the Lansing and Jackson MSAs. More analysis will be done to identify barriers to care for these groups. Surveillance has been requested to provide more demographic analysis of the geographic areas with the highest levels of unmet need so that outreach and services can be targeted more effectively.

The unmet need estimate and assessment were completed too late to be included in the Part B Care Needs Assessment of 2006, (the next analysis of data will begin in October 2008) but will be incorporated as part of the needs assessment process beginning in 2009, since it is based on reliable and comprehensive data and produces useful information. The 2009 needs assessment will be used to begin to assess the barriers and service gaps of the populations identified as having high levels of unmet need.

B. BUILDING SYSTEM CAPACITY AND EFFECTIVENESS THROUGH COLLABORATION AND COORDINATION

The health resources that comprise our system of HIV/AIDS were not developed from a single, master blueprint. They came from a variety of innovations and reactions to the problem of HIV/AIDS. The challenge now, as in the past, is to facilitate effective ways to collaborate and coordinate relationships, programs, and organizations so the highest benefit for the greatest number of clients is realized.

1. Link prevention and care services

Michigan is committed to strengthening a full continuum of care for the entire state. Various planning activities can provide opportunities for education or cross-training in various service areas. They can also serve as opportunities to learn about the unique needs and issues of various target populations. The Michigan HIV/AIDS Council (MHAC) serves as the statewide planning body for both care and prevention planning and provides an ongoing opportunity for the exchange of information and ideas necessary to improve the linkage between prevention and care services.

Linkages between prevention and care have been developed to maximize access to HIV counseling and testing, risk reduction, and early intervention services. HIV counseling and testing is necessary so that people infected with HIV can learn their status regardless of where they access testing services (e.g., CBOs, health department or HIV care provider). Risk reduction services are necessary so that persons who do not know their status, or who have put themselves at risk, will refrain from putting others at risk. These services are also intended to help those who do not know their status to become motivated to get tested and to help those who have tested HIV positive maintain a high quality of life. There are currently eight agencies in Michigan that conduct the Prevention for Positives Program, which is the only mechanism for bridging counseling, testing and referral and case management/care services. Whether it is a trained case manager doing client-centered risk reduction counseling to an HIV positive client, or a trained program facilitator providing a funded Prevention for Positives Program, Prevention for Positives' activities are designed to be utilized from either care or prevention platforms. The Prevention for Positive Program is currently not funded statewide.

2. RW cross-Parts collaboration

The RW HIV/AIDS Treatment Modernization Act of 2006 provides funding for a wide array of health care and support services. Leveraging the categorical resources delivered to the state for RW Parts A - D, AETC, and dental services is a key expectation of the legislation. The content of this document indicates that, at least in certain settings and among certain organizations, some level of effective collaboration and coordination is on-going. Moreover, there is a clear awareness and commitment to building collaborative capacity across all Parts at multiple levels. All Parts meetings are also held twice a year to update All Part's representatives on the Division of Health, Wellness and Disease Control activities, as well as hear updates on activities being conducted by all Parts and the AETC.

The following is a list of all Michigan Ryan White Grantees:

MICHIGAN RYAN WHITE GRANTEES

Part	Grantee	Grant Number	Program Director
	Detroit Public Health Department	H89HA00021	Renee McCoy
Part A: Hard Hit Urban Areas			
	Michigan Department of Community Health	X07HA00044	Debra L Szwejd
Part B: Part B State Formula Grants/AIDS Drug Assistance Programs			
	Detroit Community Health Connection	H76HA00117	Wayne W Bradley, Sr.
Part C: Community Based Early Intervention			
	St. Mary's Health Care	H76HA00110	Lori Whilden
Part C: Community Based Early Intervention			
	The Regents of the University of Michigan	H76HA00182	Powel Kazanjian, MD
Part C: Community Based Early Intervention			

Part C : Capacity Development and Planning Grants Community Based	St. Mary's Health Care	P06HA08879	Lori Whilden
Part D Women, Infants, Children, Youth and Affected Family Members AIDS Healthcare	Michigan Department of Community Health	H12HA08505	Debra L Szwejd
Part F Special Projects of National Significance	Wayne State University	H97HA03785	Angulique Y Outlaw
Dental Reimbursement Program Grant Recipients	University of Detroit Mercy, School of Dentistry		
Ryan White Part A Minority AIDS Initiative Grant Program	City of Detroit	H3MHA08480	Renee McCoy
Ryan White Part B Minority AIDS Initiative Grant Program	Michigan Department of Community Health	G24HA08493	Debra L Szwejd

The Ryan White (RW) Cross Parts Collaboration initial meeting was hosted by the Michigan Department of Community Health (MDCH-Parts B and D) and the Detroit Department of Health and Wellness Promotion (DDWHP-Part A) in January 2007. The purpose of the collaboration was and still is to develop a partnership between Michigan's RW Parts A, B, C, and D to coordinate quality improvement activities across Parts to reduce the administrative burden for providers, to use similar or the same indicators across the Parts, to share quality improvement data, and most importantly to improve health outcomes for Michigan's Ryan White consumers.

At this time, administrative, quality, and data representatives from Parts A, B, D, and two case management agencies are participating in the current Cross Parts initiative. Of Michigan's four funded Part C programs, three are choosing to participate.

To date, there have been two large group meetings. The initial meeting in January 2007 and a second meeting May 2008 were held to reinvigorate the commitment to the Cross Parts Collaboration process. From the January 2007 meeting a data and capacity work group was formed. In the winter of 2007, the data working group decided on five quality indicators that were applicable to Parts A-D. They are:

- 65% of clients with HIV will have a CD4 count and viral load at least every six months.
- 75% of eligible female clients with HIV infection will have a minimum of one Pap/pelvic examination annually.
- 60% of clients with HIV infection will receive HIV medication adherence counseling at least every six months
- 75% of clients with HIV will have a medical visit with an HIV specialist at least every six months
- 90% of clients with HIV will have a case management care plan documented and updated at least every six months.

All MDCH Part B and D funded agencies have been responsible for reporting on the five above indicators since October 2007.

The May 2008 meeting generated a renewed commitment to the collaboration. Since May, the group has met for a second time to come to agreement on additional and/or different quality indicators based on the HIV/AIDS Bureau published indicators, as well as to develop a state wide quality management plan. Additionally, three working groups have been formed regarding data, training, and standardization.

3. Cross-service domain collaboration

The goal of cross-service domain collaboration is key given the problem of increasingly prevalent and diverse trends in HIV co-morbidity. It may also be the point with the largest gap. Bridging HIV/AIDS resources with those of mental health, substance abuse, and STDs is a huge challenge. DHWDC will work to enhance mental health services for PLWH/A; improve the relationship between case managers and managed care, foster and support agencies; disseminate information about HIV/AIDS resources; and train social workers on HIV issues by revising current HIV/AIDS standards of care as needed.

One example of cross-service collaboration in Michigan communities are the Multi-Purpose Collaborative Bodies (MPCBs), which exist in every county. Organizations that historically have been involved in the MPCBs include substance abuse and mental health providers, workforce development councils, aging councils, child abuse and neglect prevention councils, United Ways, local public health departments, and at least one County Commissioner. HIV/AIDS organizations and PLWH/A involvement in these existing community groups may help to begin bridging the gap in cross-service collaboration with other human service providers in communities.

4. Public-private partnerships

The need for collaboration and coordination among public institutions and private organizations underscores the reality that a publicly funded (i.e., taxpayer financed) system will eventually reach a limit to the number of clients it can adequately serve without additional, non-public resources on hand. The goal is to build partnerships on multiple levels with non-public entities to solve problems, such as inadequate transportation services for PLWH/A in rural and urban locations. Businesses of any variety and philanthropic foundations, such as the Michigan AIDS Fund, the Kellogg Foundation, and the Skillman Foundation are each excellent resources that are likely to fund innovative, direct-service initiatives for HIV/AIDS prevention and care.

5. Urban, suburban, and rural services integration

“Ruralness” limits the capacity of non-urban, non-suburban communities to independently develop and deliver prevention and care services. In order to address the needs of rural communities more effectively, collaborative initiatives that foster greater exchange between prevention and care service organizations, county planning bodies, and PLWH/A from across the state are needed. Through such collaboratives, innovative ways of building a more accessible service infrastructure for rural communities can be realized. For example, a statewide virtual information system may be particularly useful for persons who live in rural communities and for migrant workers.

6. Faith-based partnerships

In the United States, faith-based community organizations (FBOs) have been providing essential services such as child welfare, medical care, child care, housing, transportation, and counseling. In doing so, they have filled or reduced existing holes in federal, state, and local governments' "safety net" of service programs.

As the demand for HIV/AIDS services continues to expand while federal and state budgets for health services in general, and HIV/AIDS programs in particular, are shrinking, partnerships between FBOs and various HIV/AIDS programs might begin to fill this void. Utilizing the strengths of FBOs, messages of prevention and awareness of care services could be disseminated, services could be provided to PLWH/A and those affected, and an extremely valuable community link between clients and service providers could be forged. Partnerships of this kind also have the potential to bring together the resources of the FBOs with the HIV/AIDS prevention and care programmatic expertise throughout Michigan.

7. University-based AETC Collaboration

A partnership with the Midwest AIDS Training and Education Center (MATEC Michigan) based at Wayne State University has been developed to:

- enhance the knowledge base of physicians who maintain small HIV practices.
- prevent perinatal transmission of HIV by increasing the knowledge and skills of medical providers who care for pregnant women.
- increase the number of providers offering HIV testing in accordance with current CDC recommendations for the testing of adults and adolescents in health care settings.
- enhance the knowledge and skills of health professions students in order to prepare a future cadre of physicians, nurses, dental professionals and pharmacists who will be prepared and motivated to reduce HIV-related mortality and morbidity.
- reduce the prevalence of co-occurring STDs, especially gonorrhea and chlamydia, in Michigan.

8. Community Partnerships

In order to reach those HIV+ individuals not in care, and to better serve those who are, the DHWDC strives to build a stronger PLWH/A community partnership. The Michigan HIV/AIDS Council (MHAC) insures that a majority of voting member seats are held by PLWH/A, and that those PLWH/A are active on various committees including developing the Care SCSN and Comprehensive Plan, as well as providing input for drafting cyclical PLWH/A survey instruments. This community partnership enables DHWDC to insure care for people living with HIV/AIDS in Michigan, particularly for core services such as health care, case management,

HIV medications, and health insurance, in addition to addressing service gaps and barriers to care. Future needs assessments must expand the current needs assessment process so that all PLWH/A in Michigan are included, not just those in case management. This will allow DHWDC to assess the needs of PLWH/A who may be out of care, as is required by HRSA. Future assessments must also allow DHWDC to measure trends over time, in order that changes can be seen in external and internal systems which may be influencing PLWH/A needs, thereby allowing DHWDC to respond more effectively. These are necessary steps to assure that PLWH/A are able to access the services they need, are receiving high-quality care, and are leading healthy lives.

C. DEVELOPING AND EVALUATING A CLINICAL QUALITY MANAGEMENT PROGRAM

COC will continue to use a variety of tools to monitor and evaluate performance of short and long-term goals. These tools have grown out of a need to ensure COC addresses PLWH/A needs, internal goals and objectives, state and federal-level policies, and gain community stakeholder input. These monitoring tools have given COC an increasingly comprehensive view of its performance as well as movement toward their vision of ensuring efficient delivery of comprehensive, quality care services to all eligible persons living with HIV/AIDS in Michigan. In order to evaluate short-term goals, COC has implemented a Quality Management Plan (QMP). The guiding principles of the plan include addressing the growing impact of the HIV/AIDS epidemic among underserved minority and hard-to-reach populations, ensuring access to existing and emerging HIV/AIDS therapies consistent with Public Health Services (PHS) treatment guidelines, adapting to ongoing changes in the epidemic and the HIV/AIDS funding environment; and documenting and evaluating outcomes for the investment of COC resources. The goals of the COC-Quality Management Plan are to:

- 1) Improve client outcomes by using a systematic process to determine the success and the quality of the service delivery system;
- 2) Assure that services adhere to the PHS guidelines, established clinical practice standards, and standards of service developed in Michigan;
- 3) Assure that clients are linked to medical care, counseling and testing programs, partner counseling and referral services, and other prevention and adherence programs, and that clients remain in care if they so choose; and
- 4) Improve the service delivery system based on results of needs assessment information, the SCSN, surveillance data, and client-level CAREWare data.

These goals have been and will continue to be accomplished through the following:

- Review and revise as necessary the COC-QMP and ensure that there are adequate staff to implement and monitor the activities and that adequate resources are budgeted for the program;

- Review and revise as necessary measures, indicators, and data collection methodologies for continuous quality improvement and quality assurance activities and facilitate regular collection, analysis and reporting of quality management and client level data;
- Issue directives, guidance, standards, and recommendations to staff and funded providers;
- Conduct quality management, quality assurance, and continuous quality improvement trainings, including the four day case management certification training;
- Review the COC-QMP plan and the annual QM report;
- Convene and facilitate an ad hoc standards of care committee, which is responsible for developing and revising standards of care and reviewing standardized forms for intake, assessment, care plan development, reassessment, monitoring, discharge, effective referrals and partner counseling and referral services. COC will guide this process;
- Conduct annual site visits to provider agencies and assess contract compliance and adherence to the standards of care at the provider level;
- Develop with the provider a corrective action plan, when warranted;
- Provide and facilitate technical assistance to providers and various quality management committees and the ad hoc work group;
- Provide service utilization data and various data analyses to providers, funders, and other partners; and
- Facilitate All Parts meetings for the purpose of sharing information on COC Part B and Part D QMP activities and to learn about Part A, Part C and Part F QM activities. The COC Unit held two All Parts (Grantees) meeting in 2008 and will hold a minimum of two All Parts meetings in 2009.

Besides this program, COC also uses as a monitoring tool the FY2008 Implementation Plan. This document identifies the direct services funded April 2008 – March 2009, and the objectives of each funded service. These services were directed by the results of the PLWH/A 2006 statewide needs assessment. Core services are included in this plan. Substance abuse is funded via collaboration with the Office of Drug Control Policy (ODCP). The *Memorandum of Understanding between the Michigan Department of Community Health and the Office of Drug Control Policy* documents how ODCP and DHWDC will work together to coordinate resources, assure effective program services among their respective providers, and conduct policy development, technical assistance, and consultation as well as training regarding HIV/AIDS, tuberculosis (TB), sexually transmitted diseases (STDs) and hepatitis in the substance abuse network. This project is known as the Early Intervention Program (EIP), with each division internally budgeting dollars to support these collaborative efforts. Although this funding cannot fully meet the need for substance abuse services, there are other needed core services (such as

ADAP, HIV case management and primary/specialty care) where no source of funding exists other than the Ryan White Part B resources.

MDCH-ODCP awards substance abuse resources to fiduciaries called Coordinating Agencies (CAs). Through their Annual Action Plan Guidance on Communicable Disease, the ODCP identifies a portion of the Coordinating Agency's (CA's) allocation can be used for intensive case management for HIV+ individuals in the substance abuse system if the need exists in their region, and such services are not available through other providers. In addition, CAs are required to describe mechanisms in place for assuring access to service for PLWH/A and/or Hepatitis C. At local, regional and state levels, collaborative relationships are in place to ensure coordination of care for persons dually-diagnosed with HIV and substance abuse.

COC will continue to address the needs of the PLWH/A community by involving this community in consumer feedback. Planned projects include surveying ADAP and dental clients on accessing current services and a PLWH/A needs assessment survey. These activities will help inform DHWDC/HAPIS, as well as organizations, of local service needs in preparation to apply for Ryan White Part B funding. Case managers will continue to be updated on care services via the annual Case Management Conference as well as through their own list-serve, where information is communicated daily.

IMPROVING CLIENT LEVEL DATA

MDCH-DHWDC has implemented the statewide deployment of CAREWare, version 4.1. A central server is being used to house data from all Part B and State-funded providers. Given the "real time" nature of the new system, we now have the capability to use more rapid monitoring of specific indicators (e.g. number of clients without medical insurance), instead of waiting for several months until the provider is required to submit reports to MDCH-DHWDC.

MDCH-DHWDC makes additional use of client level data with the implementation of CAREWare 4.1 since each agency data reflects their funded contract services. CAREWare allows the sharing of information between agencies, thereby improving referral times, the tracking of clients, as well as tracking quality indicators. CAREWare can also track the Counselor-Assisted Referral Form and allow for the easy running of reports.

USING DATA FOR EVALUATION

Data and information have been used to target programs and resources in certain parts of the state. For example, client level data was evaluated prior to the allocation of Part B Minority AIDS Initiative resources to southwest Michigan and southeast Michigan. Additional resources are targeted toward minority and hard-to-reach populations for the purpose of improving access to, and retention in, medical care and supportive services.

Michigan participated in the Part B Quality Collaborative (QC) that was initiated by HRSA in summer of 2005. The QC Team consisted of seven members, including surveillance (epidemiology) and data management staff. The team completed the third learning session in November 2007 and was a full participant throughout the entire project. A positive part of this collaborative was the ability to include some of our existing efforts, such as the deployment of

CAREWare 4.0, Medicare Part D, and the implementation of our first standardized form to assess payer of last resort into our learning objectives for this effort.

MEASURING CLINICAL OUTCOMES

Contract monitoring is one of the most effective ways to assess the quality of services and is also a critical component of quality management.

The use of the three specific contract monitoring tools will continue. In addition to site visits, a staff team with expertise in case management, contract management, and data management meet once each quarter to review provider progress reports, fiscal trends, client utilization data, site visit results and any issues of concerns. Appropriate follow-up, if necessary, is discussed and assigned to the appropriate COC staff for follow-up action.

Some activities that have been implemented to improve the service delivery system include the:

- Development of service standards for case management and client advocacy, and development of a tool to assess financial eligibility;
- Development of provider/contractor work plans that focus on outcomes;
- Development of contract requirements that require compliance with standards, and stipulate reporting of quality assurance activities;
- Collection and analysis of contractor data, including fiscal reports, utilization data, and narrative progress reports;
- Conducting training on program and administrative issues, and an ongoing training and certification for HIV/AIDS case managers;
- Ongoing communication with providers, technical assistance, face-to-face meetings, and telephone and electronic communication, including the use of a Case Manager listserv and a listserv for executive directors and program managers.

Additionally, the COC Unit will continue to work with providers to refine, as needed, a standardized acuity scale, which is required of all HIV/AIDS case management agencies funded with Part B and state resources. This tool is used to assess the degree to which medical and non-medical services, such as case management, will improve health and retention in medical care for those receiving services.

Since the development of the original HIV/AIDS case management standards, MDCH-DHWDC has conducted case management reviews to assess compliance with the standards of service for case management. In the past, some of the requirements were related more to record keeping and timeliness of intake, assessment, service plan development, monitoring, reassessment and discharge, rather than the “quality” of case management or the effectiveness of the case management referral system. Through the use of an acuity scale to assess the level of need, Michigan’s HIV/AIDS care network has begun to move in a new direction, toward outcome measurement. Outcome indicators are now linked to the acuity scales, as measured on

intake/assessment and during reassessment, to document health outcomes of clients receiving case management and/or client advocacy services.

At this time MDCH-DHWDC is monitoring the following indicators: 1) the number of persons receiving a CD4 and viral load test in the past six months; 2) the number of persons receiving case management services with a completed financial assessment in the past six months; and 3) the number of persons receiving case management services with a completed HIV transmission risk assessment in the past year.

As part of COC's vision to ensure efficiency and to evaluate our own progress, this completed SCSN and the statewide Care Comprehensive Plan will be distributed to all HIV/AIDS providers in order that they are knowledgeable of the COC program. In keeping with the added emphasis on quality management and accountability, it is imperative all stakeholders involved in HIV/AIDS care services are aware of the principles used to strengthen the Ryan White HIV/AIDS Treatment Modernization Act of 2006 in order to move forward in creating a healthier Michigan.

APPENDICES

RYAN WHITE PROGRAM SERVICES DEFINITIONS

CORE SERVICES

Service categories:

- a. *Outpatient/Ambulatory medical care (health services)*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under Outpatient/ Ambulatory medical care.
- b. *AIDS Drug Assistance Program (ADAP treatments)*** is a State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.
- c. *AIDS Pharmaceutical Assistance (local)*** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are **not** funded with ADAP earmark funding.
- d. *Oral health care*** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
- e. *Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

NOTE: EIS provided by Ryan White Part C and Part D Programs should NOT be reported here. Part C and Part D EIS should be included under *Outpatient/ Ambulatory medical care*.
- f. *Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health

insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

- g. *Home Health Care*** includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, diagnostic testing, and other medical therapies.
- h. *Home and Community-based Health Services*** include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.
- i. *Hospice services*** include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.
- j. *Mental health services*** are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.
- k. *Medical nutrition therapy*** is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.
- l. *Medical case management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
- m. *Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

SUPPORT SERVICES

- n. Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
- o. Child care services** are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training. **NOTE:** This does not include child care while a client is at work.
- p. Pediatric developmental assessment and early intervention services** are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.
- q. Emergency financial assistance** is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

NOTE: Part A and Part B programs must be allocated, tracked and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formally Policy No. 97-02).
- r. Food bank/home-delivered meals** include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.
- s. Health education/risk reduction** is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.
- t. Housing services** are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

- u. *Legal services*** are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.
- v. *Linguistics services*** include the provision of interpretation and translation services.
- w. *Medical transportation*** services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.
- x. *Outreach services*** are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.
- y. *Permanency planning*** is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
- z. *Psychosocial support services*** are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.
- aa. *Referral for health care/supportive services*** is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.
- ab. *Rehabilitation services*** are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.
- ac. *Respite care*** is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.
- ad. *Treatment adherence counseling*** is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

FY 2007 Part A and Part B Fundable Program Services List

Core Medical Services	
a.	Outpatient /Ambulatory health services
b.	AIDS Drug Assistance Program (ADAP) treatments
c.	AIDS Pharmaceutical Assistance (local)
d.	Oral health care
e.	Early Intervention Services
f.	Health Insurance Premium & Cost Sharing Assistance
g.	Home health care
h.	Home and Community-based Health Services
i.	Hospice Services
j.	Mental health services
k.	Medical Nutrition Therapy
l.	Medical Case Management (including Treatment Adherence)
m.	Substance abuse services–outpatient
Support Services	
n.	Case Management (non-Medical)
o.	Child care services
p.	Emergency financial assistance
q.	Food bank/home-delivered meals
r.	Health education/risk reduction
s.	Housing services
t.	Legal services
u.	Linguistics Services
v.	Medical Transportation Services
w.	Outreach services
x.	Psychosocial support services
y.	Referral for health care/supportive services
z.	Rehabilitation services
aa.	Respite care
ab.	Treatment adherence counseling

NOTE: Part A and B Ryan White grant funds may be used to support ONLY the service categories listed above. The *Ryan White Program Service Category Definitions* list includes additional categories that are fundable under Part C and/or Part D only.

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RW GRANTEES AND REVIEWERS

Karen Boyd	Detroit Community Health Connection (Ryan White Part A and C)
Kristin Durell	McAuley Health Center (Ryan White Part C)
Mary Rose Forsythe	Midwest AIDS Education and Training Center (MAETC)
Elizabeth Hamilton	HIV/AIDS Surveillance Section, Michigan Department of Community Health, Bureau of Epidemiology
Peter Hubbard	Needs Assessment Committee Co-Chair
Angulique Outlaw	Wayne State University (Horizon's Project) (Part F: SPNS)
Mark Peterson	Division of Health, Wellness and Disease Control, HIV/AIDS Prevention and Intervention Section, Community Partnerships-Prevention Unit
Andrea Roberson	Detroit Department of Health and Wellness Promotion (Ryan White Part A)
Felix Sirls	Needs Assessment Committee Chair
Debra L. Szwejda	Michigan HIV/AIDS Council Chair, HIV/AIDS Prevention and Intervention Section Manager, Division of Health, Wellness and Disease Control, Michigan Department of Community Health (Ryan White Part B)
Laura Wright	University of Detroit Mercy (Ryan White Title Part F: Dental)
Patrick Yankee	Maternal Child HIV/AIDS Program, Michigan Department of Community Health (Ryan White Part D) Division of Health, Wellness and Disease Control, HIV/AIDS Prevention and Intervention Section, Continuum of Care Unit Manager (Ryan White Part B)

All other members of the Michigan HIV/AIDS Council Needs Assessment Committee.

**MICHIGAN HIV/AIDS COUNCIL (MHAC)
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